DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Disability and Elder Services
DDE-810 (Rev. 02/2005)

MEDICAID WAIVER PROGRAM HEALTH REPORT

Use of form: Personally identifiable information collected on this form is confidential and will be used for identification purposes and to document the individual's health information necessary in determining eligibility for services. Completion of this form is necessary to meet the requirements of Wis. Stats. 46.27(11) and 46.277(4).

Instructions: Complete within 90 days (before or after) the Waiver Start Date and annually within 90 days (before or after) the Waiver recertification month for each CIP II or COP-W participant.

A. TO BE COMPLETED BY CASE MANAGER

Name – County Agency

Name – Participant (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Name – Clinic / Office	Physician's Telephone Number

B. TO BE COMPLETED BY PHYSICIAN OR REGISTERED NURSE

1. Describe participant's diagnosis (i.e., disabilities / impairments / rehabilitation potential / prognosis). List primary diagnosis first. If necessary, attach additional documentation.)

1a. Condition is considered: ☐ Stable ☐ Unstable (Check one.)

2. List name of medications, dosage and frequency. Include injections, prescription and over-the-counter medications ordered. If necessary, attach additional documentation.

2a. ☐ Yes ☐ No Medications should be supervised. (Check one.)

3. Physician's Orders

a. Therapies / home health (Check all that apply.)

☐ Home nursing care
☐ Occupational therapy
☐ Physical therapy
☐ Home health aide
☐ Speech therapy
☐ Assistance with housekeeping / chores
☐ Personal care
☐ Physical therapy

b. Treatments

☐ Oxygen
☐ Dialysis
☐ IV meds
☐ Decubiti care
☐ Ventilator
☐ Ostomy care
☐ Suctioning
☐ Transfusions
☐ Chemotherapy
☐ Catheter – Type: _____
☐ Feeding tube
☐ Parenteral / IV
☐ Severe pain
☐ Radiation
☐ Range of motion
☐ Other – List below.

_____
_____
_____

4. Ongoing diagnostic tests required – type and frequency	5. Diet / nutrition – List special instructions

SIGNATURE – Physician, Physician Assistant or Registered Nurse	Date Signed

CASE MANAGER – See page 2

C. COMPLETION OF ITEMS 1 AND 2 BELOW ARE OPTIONAL.

If part C is completed, the information should be provided by the care manager, nurse or another professional familiar with this applicant / participant. Enter information not found on the Long Term Care Functional Screen or the Assessment / Supplement, or that is missing from page one of this form.

1. Describe mobility / activity limitations. List DME or adaptive aids needed.

2. Other relevant information: Mental status, orientation, communication, social abilities, special health needs or other applicant / participant-specific information that substantiates the level of care determination.

Name – Person filling out part C	Title